Individualized Health Care Plan

Demographics

Student Name _____ Birth Date _____

Home Address _____

_____

Mother/Guardian _____ Phone _____

Father/Guardian _____ Phone _____

Language spoken at home _____

Emergency Contact:

_____	_____	_____
Name	Relationship	Phone

Medical Care

Primary Physician _____ Phone_____

Specialty Physician _____ Phone_____

Health History

Brief health history

_____

_____

_____

_____

Special health care needs

_____
_____
_____
_____

Student's Ability to Participate in Care

_____
_____

Allergies

_____
_____

Other

_____
_____
_____
_____
_____
_____
_____

Prepared By: _____ _____
School Nurse Date

Approved By: _____ _____
Parent(s) Date

_____ _____
Parent(s) Date

Approved By: _____ _____
Student Date

Approved By: _____ _____
Medical provider (optional) Date

Next Review & Revision Due: _____

By signing this form, authorization is hereby granted to release this information to appropriate school or bus personnel and classroom teachers as needed.

MHD 3-14